DOCUMENT RESUME

ED 424 785 FL 025 586

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TITLE	A Sociolinguistic Analysis of Doctor-Patient Communication.
PUB DATE	1998-01-31
NOTE	10p.; In: The Japan Conference on English for Specific Purposes Proceedings (Aizuwakamatsu City, Fukushima, Japan, November 8, 1997); see FL 025 575.
PUB TYPE	Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	*Code Switching (Language); Discourse Analysis; *English for Special Purposes; Foreign Countries; Group Membership; Interaction; *Interpersonal Communication; *Language Patterns; Language Research; Language Role; Language Styles; *Physician Patient Relationship; Physicians; *Questioning Techniques; Sociocultural Patterns; Sociolinguistics
IDENTIFIERS	Turn Taking

ABSTRACT

This study analyzed doctor-patient communication from a sociolinguistic perspective, focusing on two issues: (1) why patients are not more effective in asserting themselves in talking with doctors, and (2) why doctors don't talk more like normal people (i.e., patients). Research on communication in health care contexts is reviewed, looking at such aspects as terminology, register, verbal interaction formats, turn-taking, the structure and timing of the doctor's questions, solidarity and status, language and group membership, and code-switching. It is concluded that the factors limiting patients' ability to assert themselves are more linguistic than social, and are related to lack of medical vocabulary, technical grammatical patterns, and the structure of doctors' questions. Factors influencing doctor's language use are related to language as an indicator of group membership, and the subsequent social implications of choosing to speak more like a patient or more like a doctor. Turn-taking patterns were found to be a central sociolinguistic element, restricting patients' opportunities for gaining a turn and imposing limitations on speaking during the doctors' questioning. Implications for practice are discussed briefly. Contains 8 references. (MSE)

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A Sociolinguistic Analysis of Doctor-Patient Communication

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Abstract

This paper is about communication in the health care setting, especially between doctors and patients, and offers a sociolinguistic perspective on this type of interaction with a focus on factors influencing the speech options of the interlocutors. The primary purpose is to contribute some viewpoints as to why doctors' and patients' speech is not more similar. The paper will consider turn-taking, interaction formats, question structures, language and group membership and code switching. The analysis of the sociolinguistic dynamics of doctor-patient communication views patients' communication as largely restricted by "linguistic" type factors and doctors' language choices as more influenced by "social" type factors. Factors such as turn-taking and conversation formats, which are viewed as central "sociolinguistic" factors, are a primary focus.

Introduction

Health care is a situation of important consequence, the success of which is greatly influenced by the information exchange. There are many information gathering procedures used by medical personnel to request detailed personal health and lifestyle information from patients. These procedures can facilitate communication and many encounters go smoothly and efficiently; however, this is not always the case. Though increased awareness of communication effects and communication skill training for health care providers and the general public may be easing some of the difficulties, it isn't always easy for doctors and patients to communicate effectively. Patients often leave medical appointments feeling unsatisfied, and health care providers feel frustrated with patients who seem to never understand their treatments and consequently return to the clinic over and over again with the same problem.

Two frequently asked questions summarize the difficulties often occurring in health care communication:

1. Why don't patients assert themselves more effectively when talking with doctors?
2. Why don't doctors talk more like normal people? (i.e., Why don't doctors talk more like patients?)

This paper proposes a sociolinguistic analysis directed towards answering these two questions by highlighting some of the elements from sociolinguistic research on health care communication compared with more general communication. Terminology and register, verbal interaction formats, turn-taking, the structure and timing of questions, solidarity and status, language and group membership and code switching will be considered. Though the overall perspective is sociolinguistic, and all elements take on a sociolinguistic character within the interaction, most elements can also be defined as more "linguistic" or more "social" (see Figure 1). It is anticipated that the answer to the first question will be

more heavily weighted by "linguistic type sociolinguistic" factors and the answer to the second more heavily weighted by "social type sociolinguistic" factors.

The difficulties patients may encounter in trying to assert themselves will be addressed first.

Terminology and Register

Perhaps the most easily identifiable element that may cause communication difficulties in doctor patient communication is medical terminology. Typical patients are not fluent in using scientific terms for body parts and functions or scientific descriptions of treatments and medications, so they cannot easily join in the conversation if the health care provider is using such vocabulary and the academic register that often accompanies that terminology. Vocabulary and grammatical patterns used for technical explanations are "linguistic" type elements.

Structure and Timing of Doctors' Questions

West (1983) observes the structure of questions asked by doctors that restrict patients' responses. Doctors often structure questions in such a way as to ask patients several questions but allow space for only one answer. Example: Any headache, fever or chills? Any pain, tenderness, discomfort? Another type of question structure is the "Is it X or is it Y?" This structure could be viewed as two questions, each requiring a yes or no answer or as a question which predetermines the answer to one of the mutually exclusive choices. Additionally, doctors sometimes begin asking new questions during the patient's answer to the previous question(s).

The structure of questions has a significantly linguistic character; however, the timing of the questions in the conversation is also important as observed by West (1983). West points out that the importance of patient's (i.e., the interviewee's) answers are decreased and structurally usurped in the verbal exchange by doctor's talking over patients' answers. All of the points noted above decrease the importance of the patients' responses since both of the question structures limit the categories of responses possible. However, an important effect of a doctor's overlapping new questions during a patient's answer is that transition points in the conversation where the patient might gain a turn, and become able to contribute to the information exchange, are also usurped; the doctor maintains her/his turn in spite of having cued the patient to speak.

West (1983) also found that, in her data, doctors answered only 87% of questions asked by patients, whereas, patients answered 98% of questions asked by doctors. When patients didn't answer, it seemed related to the structure of the doctors' questions. When patients asked questions, doctors often responded with more questions.

The timing of doctors' questions is an element with more social character. In normal conversation, though some overlap of speakers may occur, beginning a new question or topic while the interlocutor is speaking is often considered an interruption and a sign of rudeness.

Turn-Taking

Doctor-patient communication frequently includes an interview of the patient by the doctor. An interview does not have the same format or interaction signals as normal conver-

sation. Generally patients are not skilled at being an interviewee, whereas they are skilled at normal conversation, and may be expecting normal conversation skills to be functional in the doctor-patient encounter. For this reason, it is of interest to review some aspects of the structure of "normal" conversation.

For background reference, the description of turn-taking done by Sachs, Schegloff and Jefferson (cited in Fasold, 1990) is of interest. The main points are the following.

There is, for the most part, "no gap" or silence between speakers and "no overlap" of interlocutors' speech. Alternation of speakers occurs through turn taking. A silent interlocutor can gain a turn to speak in the following ways:

1. The current speaker selects another interlocutor to take the floor, often by asking a question.
2. Self-selection of a new speaker at a transition relevance place in the interaction.
3. The current speaker pausing, thereby creating a silence and transition point, no new speaker begins to talk, the current speaker continues.

For a two person conversation, the number of turns per speaker is approximately 50%. A speaker may speak briefly or at length. Questions may be initiated by either speaker. Topics may be introduced by either speaker.

Turn-taking is a necessary mechanism for the exchange of spoken language between interlocutors. It is part of the total language system which is necessary for spoken structures an meaning to be understood. Because it allows for this exchange between participants it also has a social character which partially structures their relationship during the information exchange. This paper considers turn-taking to be a central sociolinguistic element.

Interaction Formats

The above is for normal conversation. Doctor-patient communication frequently, if not usually, follows an interview format with the doctor asking the questions and the patient mainly supplying answers. The interaction procedures and signals are not the same as those existing in normal conversation. Shuy's (1983) work explains that most people have normal conversation skills (as described above), and they are not prepared for the interaction format of an interview, either as an interviewer or as interviewee. Doctors, like other interviewers, are prepared ahead of time and know many of the questions they will ask. People who know they are going to be interviewed anticipate questions and prepare answers; however, people going to see their doctor to receive medical care, a service, are not necessarily consciously expecting to be interviewed.

Research concerning dentist-patient communication done by Candlin, Coleman and Burton (1983) offers support for Shuy's (1983) work. Candlin et al. talk about the "discoursal set" of dentist-patient communication and the "discoursal set" of normal conversation pointing out that patients, for the most part, do not have specialized experience in using the discoursal set of the dentist-patient encounter. Consequently, patients may perceive the dentists' interactional cues to be the same as the signals they are familiar with in normal conversation and try to react to these cues accordingly.

In a normal conversation, when one interlocutor asks another a question, the floor is yielded allowing the new speaker to speak at length, including the options to ask questions or to introduce new topics. In an interview, the interviewee does not have unlimited time to answer questions, and is not expected to ask the interviewer questions. In health care contexts, the patient is asked many questions, but is certainly not given the floor to answer at length; concise answers are expected, and those answers may even be interrupted by additional questions (see West 1983).

In normal conversation, the speaking turn distribution is approximately equal between two interlocutors. Candlin et al. (1983) observed that in dentist-patient discourse, the discoursal set provides more turns for dentists than for patients. From some of their transcripts, we can see that patients do talk and can offer information, but the information may be ignored if it does not comply with the format of the dentist-patient discoursal set. In order to comply with this format, Candlin et al. observed that patients had to wait for a "cue" from the dentist in order for their information to be acknowledged as actually heard and admitted into the conversation.

So, although pátients may sometimes attempt to assert themselves by using normal conversation strategies, which allow either interlocutor to introduce topics, the structure of the discoursal set does not require the health care provider to admit the patient's information into the exchange unless a cue is given. The interview format clearly gives topic control to the interviewer.

These formats, which include special details for turn-taking, are also central sociolinguistic factors affecting doctor-patient communication. The normal conversational turn-taking system is not operational for the patient (who may be attempting to use those interaction rules), and the operating rules of the interview (Shuy, 1983) and the doctor-patient discoursal set (Candlin et al., 1983) favor the health care provider as the dominant interlocutor.

The medical interview differs from many other interviews, however, in that in many interviews, it is the interviewee who is the star of the interview. The star also often receives the most time to talk and elaborate on their ideas. The view point of the interviewee is the focus of interest. The health care interview does not allocate this position of stardom to the patient.

The doctor-patient interaction has been described as an interview, but it seems to be more of a questionnaire – a specific type of interview, often done by the interviewer reading a series of questions – asking for very condensed short answers, yes or no or multiple choice responses. The questionnaire analogy is probably accurate. At least part of the medical history exists on a pre-prepared written form from which the health care provider may be reading and on which the health care provider may be recording the patient's responses. The information needed to fill in such forms is well known, so it is not surprizing that the patient interview takes on some characteristics of the health care provider reading a questionnaire – for the hundredth time.

In effect, the health care provider is rehearsed in this type of communication situation – and even has a written script consisting of pre-prepared health care forms – whereas the patient can only ad lib. Who is rehearsed and who is not, is an additional social type element; here again, the patient is less prepared than the health care provider and less

able to seize the floor in order to speak.

Summarizing the discourse structures which work against patients' ability to verbally assert themselves, we can list the following:

- Medical terminology and academic register.
- Doctor's Questions:
  Multiple questions asked in continuation during the doctor's turn to speak.
  "X or Y" or multiple choice type questions.
- Interview format.
- Cues for patient to speak are controlled by doctor.
- Overlap of doctors' questions during patient speaking turns.
- Doctor is "rehearsed" as the interviewer; patient is not prepared as the interviewee.

All of these factors result in a very uneven turn distribution with very few pauses or transition points to allow self-selection of speakers.

Of course, there are additional social and socio-economic factors which contribute to patient non-assertion, but the linguistic and sociolinguistic factors mentioned above are more than enough to decrease patient's possibilities for verbal self-assertion.

Language and Group Membership

Turning to the question as to why doctors don't talk more like patients, the concept of language as an indicator of group membership will offer some insight into the effect of the more "social" type of sociolinguistic elements affecting language choices in interactions. The concept of solidarity and status is also influential.

Speaking more "like patients" means approaching the use of normal conversation format and normal conversation turn taking patterns, i.e., the conversation format for which patients do have skills and experience. Consequently, patients would have more strategies to assert themselves as interlocutors if doctors used normal conversation formats, and patients could gain interactional status if the discourse format used in doctor-patient communication were more suited to their skills. Following from this, it could also be supposed that patients might be able to offer more information, participate more fully and take more responsibility for their health care.

An individual's choice of vocabulary, register, style, dialect or other language, not only accomplishes communication but also serves as a way of identifying group membership of the speaker and the relationship between the speaker and listener. "Speaking the same language" is one way to establish rapport with an interlocutor, but "speaking the same language" also, in a way, classifies the two participants as members of the same group. If doctors did indeed choose to speak more like patients, such choice of language might very well signal to the patient the doctor's desire for solidarity. The interpretation that the doctor wishes solidarity with the patient could imply giving up the power and status that the doctor has relative to the patient. Though communication might be facilitated, there could also be concerns about the status of the doctor. The doctor's authority as the expert is also supported by the fact that doctor's do not talk like patients.

When we want status, we often sacrifice solidarity – at least momentarily, and when we want solidarity, we sacrifice status, meaning we give up association with power concerning

our relationship with our interlocutor. (For background on solidarity and status, see Brown & Gilman cited in Fasold, 1990.)

When doctors speak like doctors, they are maintaining their solidarity with other doctors and the tradition of medicine – which is intertwined with traditions of higher education associated with higher socio-economic power and status. When doctors speak like doctors, they mark themselves as members of the group "doctors." In addition to marking the group membership, "doctor talk" also marks doctors as non-members of the lower educated, lower socio-economic status group to which many patients belong. In effect, it may be precarious for a doctor's professional and social identity to "talk like a patient."

Herman (cited in Fasold, 1984) elaborates on the problem of language suggesting that bilingual speakers may find themselves in more than one psychological situation simultaneously. In a particular interaction, the language which a speaker chooses will be influenced by the speaker's language preference and the language which the interlocutor or the social setting may expect. Additionally, the speaker's choice may be influenced by "background" groups from the "wider social milieu" (Fasold, 1984, p. 187). A speaker may wish to be identified as a member, or as a non-member, of a group which is not necessarily present in the immediate communication situation. Though doctor-patient communication, as discussed here, does not involve different languages in the traditional sense, registers and styles can be considered types of codes or language variants which can be chosen by the speaker. In this sense, Herman's concepts can be applied, and may help explain the idea that doctors maintain their membership in that group, even though other doctors are not necessarily present, through maintaining jargon and academic register and/or maintaining the formats which do not use normal conversation cues.

Code Switching

Doctors, in addition to their profession, have a personal life and have themselves been patients (of other doctors) at some point in their lives. However, most patients have never been doctors. Any possibility of change or intervention in the structure of doctor-patient communication also lies in the hands of the doctors who know how to be patients as well as how to be doctors.

Code switching (for a discussion of code switching and social relations, see Scotton, 1988) between "doctor talk" and "patient talk" is a possibility for the doctor but not for the patient. As there may be other medical/technical personnel or patient's family members present in the medical encounter, the doctor may be alternating between medical terminology and more common terminology depending on to whom she/he is speaking (see Tannen Wallat 1983).

Though many health care personnel do switch between medical jargon and more general terminology, and also between "academic register" and more general register, when talking with patients, health care professionals do not necessarily switch between interview format and normal conversation format. If the turn-taking format does not approach that of normal conversation, the doctor may never be speaking the patient's "language," and the overall interaction may never be completely within the patient's "code," even though lexicon and sentence patterns may be modified.

Mishler (1984) describes medical care communication from another point of view. He uses

the concept of voices: the "voice of medicine" and the "voice of the life world." In his analysis, both the doctor and the patient can use both voices. Though this seems clearly a type of code switching, it involves a kind of topic element as well as structures. Following through with the necessary medical procedures and protocols is important to both doctors and patients, so they both interact using the voice of medicine to accomplish these details. The voice of the life world is used to signal aspects of the situation that have more personal meaning for the patient. In his analysis of recorded medical interviews, Mishler observes that some doctors attend to the voice of the life world and switch into that voice or that code. He also observes that some doctors do not attend to the voice of the life world.

Though Mishler (1984) does not directly discuss sociolinguistics, his concept of "voice" is very parallel to a type of register or style which this paper has referred to as "code." When using this voice the focus is on an aspect of health or health care that is relevant to that particular patient's life situation. This does not necessarily involve collecting information, but rather acknowledgment of particular lifestyle details that are of importance to that patient. The interactions for these topics seem much more like normal conversation. So, in a sense, the topic seems to indicate the appropriate voice or code. Likewise, the language being used indicates what kind of topic, technical or personal, is being attended to. Doctors who are able to use both voices are able to code switch. From this perspective, patients also have the possibility to code switch in that they can comply with the interview format of the voice of medicine or the more normal format of the voice of the life world when it is in effect. For the most part, however, it is still up to the doctor to initiate a life world topic or to acknowledge and address the life world topics that the patient introduces.

In attempting to understand why doctors often do not speak more like patients, the association of language with group membership is a key factor.

Continuum Categorization of Factors in Health Care Communication which may Obstruct Doctors and Patients from Speaking "the same language."				
Linguistic Type Factors ..... Sociolinguistic ..... Social Type Factors				
Medical **Terminology** Academic Grammatical Patterns **Structure of** Doctor's **Questions**				
	Interview format Non-adherence to conversational **turn-taking patterns** Few points at which the Patient Can Gain a Turn			
		Doctor's **option to code switch** between medical interview language and normal conversation Lack of option for patient to code switch		
			Overlap of doctors questions while patient is speaking	
				Status of doctor Language as an indicator of **group membership**
				Socio-economic differences
Linguistic ..... Sociolinguistic ..... Social				

Figure 1

Figure 1 suggests a categorization of the elements considered in this analysis on a continuum from linguistic to sociolinguistic to social. In the communication setting of the doctor-patient interaction, all elements contribute to the sociolinguistic dynamics, and subsequently have a sociolinguistic character. However, in considering each element individually and which interlocutor is affected most, patients seem to be restricted by the more linguistic type elements, and doctors' language choice may be influenced by the more social type elements. Central sociolinguistic elements, such as turn-taking, seem to favor the physician.

Summary and Conclusion

This analysis of doctor-patient communication has offered one explanation of why doctors and patients do not speak more alike. The approach has applied sociolinguistic concepts, and has attempted to categorize these factors on a continuum as being more linguistic or more social. The types of factors which limit patients' ability to assert themselves are found towards the linguistic end of the continuum. These include medical vocabulary, technical grammatical patterns, and the structure of doctors' questions. The factors which influence doctors' language choice are related to language as an indicator of group membership and the subsequent social implications of choosing to speak more like a patient or more like a doctor.

The turn-taking patterns found in normal conversation as compared to turn-taking in doctor-patient communication is considered to be a central sociolinguistic element. Doctor-patient communication often follows a format which restricts patients' possibilities for gaining a turn, and also imposes additional restrictions on patients' ability to speak through the structure and timing of doctors' questions.

A closer look at formats and turn-taking mechanisms has also indicated the importance of considering the interactional formats and turn-taking rules in codes and in code switching. It is not only terminology and grammatical styles that influence information exchange but also the interaction rules and the distribution of speaking turns.

This analysis is not per se a criticism of all doctor-patient interactions. Normal conversation could be much less efficient than the doctor-patient interview format in many cases. However, patient responsibility and also rapport with patients are also concerns from legal and ethical perspectives. So, awareness of communication that accomplishes patient participation and rapport building is of interest. Additionally, many doctors are interested in communication, and some are more communicatively accessible to patients than others, but these are not necessarily typical doctors. Also, we can infer that patients who have more education and higher socio-economic status have more possibilities to assert themselves when talking with health care providers. These patients have more than normal conversation skills (through educational and social experience) and they know how to "talk more like doctors" at least in the sense of register.

The purpose has been to increase awareness of these linguistic, sociolinguistic and social elements, and to understand them in the context of normal conversation patterns compared with health care encounters. Many interactions may be smooth, but where interlocutors have concerns, this information may offer some insight as to what types of intervention might be attempted. Specifically, awareness of turn-taking cues may allow the health care provider to go beyond simply changing terminology from technical to common in order to

facilitate information exchange with patients.

The studies on which this paper is based have been done in English speaking situations, but the principles may be applicable to other languages. As life becomes more international we may not be able to anticipate every communication need or problem However, an ability to observe our communication experiences and consider the possible sources when difficulties are detected can allow us to develop communication interventions and strategies.

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